nebraska total care™

Care Management

An Integrated Model of Care

DHHS Behavioral Health Integration Advisory Committee Presentation

7/11/16

Topics

Care Management Program Overview

Outreach

Care Management Functions

Community Collaboration

Contact Information

Q&A

Care Management Program Overview

Levels of Care Management

1. Consultation
2. Disease Management
3. Care Coordination
4. Intensive Care Management

Care Manager and Team Assignment based on 4-Quadrant Model

Integrated Care Team utilizes Wrap-Around Approach

Outreach

Proactive member identification

- Predictive modeling software utilized to identify high risk behavioral health members, including the SPMI population

Various additional referral sources

- Member
- Provider
- Agency
- Internal staff

Outreach

Member Contact based on Priority

Critical / High

- Unstable and/or have a chronic or complex condition with ongoing behavioral health or medical needs.
- Currently hospitalized.
- Symptomatic and at risk for immediate ED visit, admission, or readmission

Moderate

- Generally stable but with multiple or co-morbid conditions.
- Have a current need for routine ongoing physical or behavioral services.

Low

- Stable with multiple or co-morbid conditions but minimal or no care management needs.
- Stable but the screening indicates a possible risk for a potential problem or complication.
- History of illness or injury but currently requires little services or the family or other caregiver is managing the care well.

Care Management Functions

- Early identification of SPMI population
- Assessment of needs
- Individualized plan of care
- Identification of barriers
- Application of appropriate interventions
- Referrals and support to ensure timely access to providers
- Active coordination of care
- Ongoing monitoring and revision of the plan of care
- Accommodating cultural and linguistic needs

Care Management Functions

Care Managers regularly evaluate member progress considering:

- Change in member status
- Change in family situation or social stability
- Change in functional capability
- Progress in reaching goals
- Member engagement
- Member’s quality of life
- Benefits and resources available

Care Management Functions

Assessments/Screenings completed by Care Management Staff

- Health Risk Screen (HRS)
- Health Risk Assessment (HRA)
- PHQ-2 / PHQ-9
- CAGE-AID
- Edinburg
- OASIS
- Others as applicable

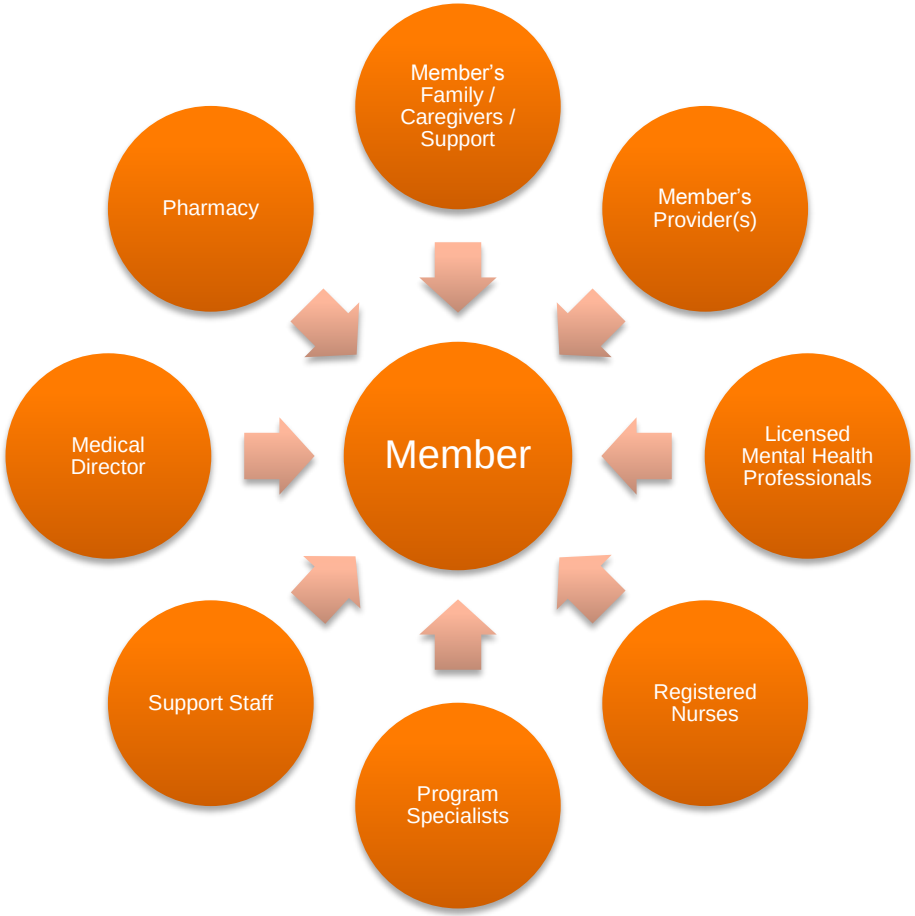
Care Plans created with member/family involvement

Care Management Functions

We recognize that multiple co-morbidities will be common among our membership, especially amongst the SPMI population. The goal of our program is to collaborate with the member and all treating providers to achieve the highest possible levels of wellness, functioning and quality of life.

- Work as a team to identify member needs and develop plans of care during Integrated Care Team Rounds
- Educate members on the importance of treatment compliance
- Help members obtain needed services
- Assist in coordination of covered services, community services, or other non-covered venues
- Follow-up on hospitalization and emergency room visits to ensure continuity of care and appropriate access of services

Care Management Functions



Integrated Care Team (ICT)

Care Management Functions

The Integrated Care Team is trained specifically on SPMI diagnoses such as

- Substance Use
- Schizophrenia
- Bipolar Disorder
- Severe Depression

Care Management Functions

All staff receive training specifically for managing SPMI population

- Identification of Co-occurring Mental Health and SUD
- Harm Reduction
- Motivational Interviewing
- Member Engagement Strategies
- Cultural Competencies
- Poverty Competency
- Recovery and Resiliency Training
- Trauma Informed Care Training
- Behavioral Health Signs/Symptoms
- Physical Health Signs/Symptoms
- Crisis Calls

Care Management Functions

Pharmacy Access

Integrated Care Team works directly with Pharmacy Staff to ensure:

- Reduce gaps in coverage
- Ensure access to information

Discharge Follow-Up

To ensure continuity of care following a facility discharge:

- 7-Day Follow-Up
  - Scheduling/Coordinating Appointments for Members post-discharge
  - Transportation Assistance
  - Incentives for Members
- Emergency Room Visit Follow-Up

Care Management Functions

Appropriate Referrals

Care Management staff refer members based on identified resources and needs to various support services such as:

- State Agencies / Services (as applicable)
- Behavioral Health and Substance Use Services
- Assistance with Financial/Utility Needs
- Support Networks / Groups
- Community Resources

Clinical and Provider Network Teams

Hold regular meetings to review provider needs such as:

- Identifying providers to add to the network
- Additional educational needed

Community Collaboration

Nebraska Total Care also provides additional training and support to providers, including:

- Screening Assessments
- Collaboration with Primary Care Providers and/or Community Agencies
- Discharge follow-up and collaboration
- Identification of care gaps
- Assisting with barriers to care
- Additional support to providers as needed

Contact Information

Clinical

Julie Lynne Rothacker, MA, PCC

Sr. Director Business Development and Clinical Implementation

Direct: 216-643-1814

Mobile: 330-730-6562

Email: julie.rothacker@envolvehealth.com

Network Contracting / Credentialing

Phone: 1-855-688-6589

Fax: 1-844-536-2997

Email: networkmanagement@nebraskatotalcare.com

QUESTIONS/COMMENTS?

Contracting/Credentialing Phone Number:
Phone: 1-855-688-6589

Thank You!